COMMITTEE ON FINANCE
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Max Baucus (D-Mont.)
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BAUCUS, HATCH REQUEST QUARTERLY REPORTS ON NEW EFFORTS TO CRACK DOWN ON WASTE, FRAUD, ABUSE IN MEDICARE, MEDICAID

Data, Regular Benchmarks from HHS, CMS Will Help Finance Leaders Continue Fraud Prevention Successes

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) and Ranking Member Orrin Hatch (R-Utah) sent a letter today to Department of Health and Human Services (HHS) Inspector General Daniel Levinson and Centers for Medicare and Medicaid Services (CMS) Deputy Administrator Peter Budetti requesting that their offices begin providing the Committee with new quarterly reports this May. The Finance leaders requested the reports detail the agencies' efforts to fight waste, fraud and abuse in Medicare and Medicaid. In the letter, the Senators asked for data, benchmarks and updates on the total number of fraud cases caught and dollars saved.

"We recovered a record $4 billion taxpayer dollars last year, and with health reform's new tools and the right oversight, that number will be even higher in the future," said Baucus. **"Our efforts to crack down on fraud will only improve with the right information and data. We need to stay ahead of the criminals who defraud taxpayers out of tens of billions of dollars each year, and these reports will provide a valuable measuring stick that will go a long way to protect Medicare and Medicaid."**

"As Dr. Budetti testified before the Senate Finance Committee earlier this year, waste and fraud within Medicare and Medicaid is costing taxpayers billions. This is unacceptable – especially at a time when our budget deficits are soaring and more Americans are relying on Medicare and Medicaid," said Hatch. **"These quarterly reports from CMS and the Office of Inspector General will ensure transparency and accountability in both Medicare and Medicaid, help safeguard taxpayer dollars – all while helping to preserve the integrity of these two programs."**

Levinson and Budetti came before the Committee at a March 2 hearing to discuss the status of new fraud prevention tools included in the health care law, which are helping CMS and HHS crack down on an estimated $60 billion lost in fraud each year. The law creates new ways for Medicare to screen health care providers before they are accepted into the program, preventing criminals and past offenders from attempting fraudulent transactions. It also creates a singular database for Medicare billing information, which allows the Departments of Health and Human Services and Justice to better coordinate and share information on past offenders and schemes. The new law also works proactively by giving officials the authority to suspend payments and investigate suspicious claims before they are paid, eliminating the need to track down fraudulent payments later. It increases civil and criminal penalties for those who commit fraud, and it increases the investment in the Health Care Fraud and Abuse Control Program, a joint effort between the Department of Justice and the Department of Health and Human Services to fight health care fraud.

The full text of the letter follows here:

March 24, 2011

The Honorable Daniel R. Levinson
Inspector General
U.S. Department of Health and Human Services
Room 5541 Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dr. Peter Budetti
Deputy Administrator and Director
Center for Program Integrity
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Inspector General Levinson and Dr. Budetti:

As a follow up to the March 2, 2011, hearing "Preventing Health Care Fraud: New Tools and Approaches to Combat Old Challenges," and in our roles as Chairman and Ranking Member of the Finance Committee, we would like to request that you begin providing our offices with quarterly reports on how each of your offices are utilizing the resources allocated for fighting waste, fraud, and abuse and the results of the use of those resources. This will better enable us to help advocate for additional resources to support your efforts in addition to providing us important oversight information about how the resources already allocated to your offices are being used. Specifically, the following are examples of the type of information requested:

Office of the Inspector General

- The amount of funds obligated each quarter from the overall current fiscal year budget and to which areas those funds have been specifically allocated (e.g., investigations, audits, evaluations, training).
- The number of exclusions initiated by actions taken by the OIG, the total number of exclusions entered into the OIG exclusion database (e.g., license revocations and other actions which did not require any specific OIG initiation), and the number of providers that have been excluded from Medicaid and CHIP as a result of an exclusion from Medicare.
- The number of individual investigations opened and number of individual investigations closed during that quarter and information regarding the disposition of those investigations (i.e., case closed with no action, conviction, recoupment of funds).
- The number of cases referred to OIG by other sources (such as CMS) and a breakdown of those by referral source.
- Total number of calls to the OIG Hotline and number of those calls which resulted in actual cases.
- Number of Corporate Integrity Agreements (CIAs) entered into and closed as well as a description of any actions taken regarding breaches of CIAs.

- Number of civil monetary penalty or other administrative actions initiated during that quarter and the sanctions or other steps taken ancillary to those actions.
- For activities initiated by the HEAT program, a breakdown by city of statistics for investigations opened/closed and enforcement results (i.e., indictments, convictions, recoveries) for each of those cities.

Centers for Medicare & Medicaid Services

- The amount of funds obligated each quarter from the overall current fiscal year budget and to which areas those funds have been specifically allocated (e.g., contractor work, data analysis, field office initiatives, provider education).
- Beginning with the March 25, 2011 implementation of the new provider screening provisions, a breakdown by industry segment (e.g., home health, durable medical equipment, physician) for each month showing how many applications were screened, the number of providers/suppliers flagged using the new screening tools, and the number of providers/suppliers denied billing numbers as a result of that process.
- The number of suspensions currently in place, any new suspensions initiated, who initiated the suspension (CMS or law enforcement), the number and length of suspensions extended, actions taken as a result of any suspensions that were lifted (i.e., was the case referred for prosecution, administrative settlement or was there an overpayment determination made).
- Information pertaining to any provider enrollment moratorium, including the type of provider, the geographic scope, the length of moratorium, and the level of access to the services/supplies in question during the moratorium.
- An update on the status of ongoing demonstration projects that utilize technology (including, but not limited to, predictive analytics) to prevent and/or identify fraudulent claim submission.
- The total number of referrals made by CMS' contractors (RACs, MACs, ZPICs/PSCs and MICs) to law enforcement, the length of time from referral until law enforcement took action on the referral and what the final action was on the referral.
- Total number of administrative actions (such as overpayment determinations, sanctions or civil monetary penalties) imposed by CMS, the duration and/or dollar value of those actions and resolution of those actions (e.g., amount paid, corrective action plan submitted).
- Total number of cases or administrative actions initiated or referred as a result of information provided through the Florida fraud hotline, 1-800-MEDICARE, Senior Medicare Patrol and/or the CMS field offices.
- Dollar amount of Recovery Audit Contractor (RAC) recoveries for that quarter by each RAC region, as well as a breakdown of RAC administrative expenses versus recoveries. Include related appeals numbers and costs that are attributable to RAC overpayment determinations. Also include a breakdown between RACs operating in Medicare fee-for-service, Medicare Part C, Medicare Part D, and Medicaid (as those RACs become operational).
- An explanation of any operational issues or delays experienced during that quarter with respect to implementing provisions of the Affordable Care Act and CMS' plan of action for addressing those delays.
- We would like to receive the first of these quarterly updates by May 20, 2011, reporting on the first calendar quarter of 2011. Each subsequent report should be published approximately six weeks after the end of the quarter. To compliment these published reports, agency staff should brief relevant committee staff when necessary. If you have any questions regarding this request, please contact Committee staff at (202) 224-4515.

Sincerely,

Orrin Hatch
Ranking Member

Max Baucus
Chairman

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